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ABSTRACT

Recognizing that unhealthy children cannot learn and that an uneducated child will become a drain on society, this report describes the efforts of the National Health and Education Consortium (NHEC) to promote collaboration among the health and education professions to improve the health of children. The report describes the creation and operation of state health/education consortia in Florida, Maryland, New Mexico, and Texas. The report recommends that leaders interested in creating, merging, or formalizing state consortia should: (1) select leadership with political access; (2) convene a formal steering committee; (3) build strong corporate involvement; (4) develop a clear mission and goals, and ensure accountability; (5) build the publics' awareness of the importance of linking health and education; (6) promote grassroots interest and activities; (7) capitalize on momentum; (8) maintain flexibility; (9) evaluate the effectiveness of the initiative; and (10) seek core funding early. Six appendixes include: a list of selected collaboration resources; NHEC founding organizations and members; and steering committee rosters and sample agendas from the Florida, Maryland, New Mexico, and Texas health/education consortia. A list of NHEC publications is included. (MDM)

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Putting Children First:

Between Education and Health

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Putting Children First:

STATE-LEVEL COLLABORATION

Between Education and Health

A Special Report of the
National Health & Education Consortium

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THE AT&T FOUNDATION

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Staff of the National Health & Education Consortium also wish to express their appreciation to each of NHEC's State Health/Education Consortia coordinators: Caroline Gaston, Marilyn Goldwater, Judy Jonas and Patsy Palmer. Without their leadership, the progress in their respective states, New Mexico, Maryland, Texas, and Florida, would not have been possible.

Special thanks are extended to the AT&T Foundation and the Honeywell Foundation for their generous assistance with NHEC's efforts to develop state-level health/education consortia as a part of a comprehensive strategy for addressing the educational and health needs of children. The AT&T Foundation provided major funding to support state activities in Florida and Texas, committed state-level AT&T representatives to work with the consortia and supported the development of this publication. NHEC's partnership with AT&T also catalyzed the evolution of consortia in Maryland and New Mexico. The Honeywell Foundation provided major support for state activities in New Mexico and together both foundations sponsored evaluation of the consortia.

Without the support of the Prudential Foundation, none of NHEC's work would be possible. It was through the vision of the Prudential Foundation that the National Health & Education Consortium was established in 1990 to promote linkages between the health and education communities. NHEC is deeply appreciative of the commitment shown by the Prudential Foundation to state health/education collaboration as a vehicle for improving the lives of children in this country.

Lastly, NHEC commends both the collective spirit and the individual efforts of its national membership (see Appendix B), and the commitment of their state and local affiliates. This unique body of organizations has provided the impetus and framework for the Consortium's activities to promote a closer link between the education and health sectors.

Preface

The mission of the National Health & Education Consortium (NHEC) is to promote increased collaboration between the fields of health and education by emphasizing the direct connection between children's health and their ability to learn, and between their educational status and long-term health. Over the past few years, NHEC has united leaders from the governance, business, education and health sectors to influence national policy and programs focusing on health and education services to children.

Of course, collaboration cannot be limited to the national level. In this time of reform, it is increasingly clear that broad-based systemic change will require vertical involvement of the federal, state and local levels; with cross-sector participation from public, private, corporate and voluntary organizations.

Recognizing the importance of interdisciplinary coordination, state government and business leaders from Florida, Texas, Maryland and New Mexico took the lead in forming health/education consortia in their states. In all four states, state-level education and health professionals joined together to develop relationships and creative strategies for resource sharing and program integration. The Consortium applauds such efforts and strongly encourages other policy makers and professionals across the country to recognize the value of collaboration and to foster the development of consortia in their states.

We hope that you will find *Putting Children First: State-Level Collaboration Between Education and Health* helpful to your thinking, planning and action at the state and local levels. Everyone has a role to play in the systemic reform of health and education, and each must assume responsibility for improving the health and well-being of our nation's most important resource — our children.

Lawton Chiles

The Honorable Lawton Chiles
Governor, The State of Florida
Co-Chair
National Health &
Education Consortium

Bill Woodside

William S. Woodside
Chairman, Sky Chefs, Inc.
Co-Chair
National Health &
Education Consortium

An Appeal To Child Advocates

Today in America, over 8 million children do not have health insurance. The uninsured rarely get the preventive health care that they need.

Today in America, it is estimated that almost 700,000 children have vision problems, many that are correctable. Children who can't see the blackboard, review the material on the computer terminal or read the textbook, can't learn.

Today in America, it is estimated that over 5 million children come to elementary school hungry. Hungry children can't learn.

Today in America, too many children come to schools that more resemble prisons — with metal detectors and bars on the windows — than institutions of learning.

Today in America, children are crying out for our help.

The National Health & Education Consortium (NHEC) was founded in 1990 on the premise that strong connections between health and education professionals were essential to ensure fundamental changes in the way children live and grow in America.

Putting Children First: State-Level Collaboration Between Education and Health is designed to be a guidebook for child advocates who share our vision. This publication describes the health/education collaboration experiences of four states. Florida, Maryland, New Mexico and Texas have taken different approaches, but for each the fundamental goal was to improve the lives of children and families in those states. These states represent only the beginning of what we hope is a nationwide effort to link two of the service systems that have such an overwhelming impact on the quality of children's lives.

The four state collaboration approaches described in *Putting Children First* are put forth as examples of what is possible. NHEC encourages consideration of these activities and recommendations in the light of individual state or locality strengths and needs.

NHEC is committed to working with state leaders across the country to improve the lives of children. As you begin your efforts to link the health and education communities in your state, we hope that you will call on the staff of the National Health & Education Consortium to be a partner in your work. Together we can ensure that children have happy, healthy and fulfilling tomorrows.

Tamara Lucas Copeland

Tamara Lucas Copeland
Director, National Health & Education Consortium
1995

Table of Contents

Executive Summary 8

Introduction 11

Health/Education Consortia: Four Models 12
- Florida 12
- Maryland 14
- New Mexico 16
- Texas 18

Recommendations for Developing a Health/Education Consortium 19

Implications for the Federal Government 20

Evaluation as Key to Institutionalization 22

Conclusion 24

Appendices 26
- A. Selected Collaboration Resources 27
- B. NHEC Founding Organizations and Roster of Members 27
- C. Florida — Steering Committee Roster and Sample Agenda 30
- D. Maryland — Steering Committee Roster and Sample Agenda 32
- E. New Mexico — Steering Committee Roster and Sample Agenda 35
- F. Texas — Steering Committee Roster and Sample Agenda 36

Publications List and Order Form 39

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Executive Summary

The recognition that an unhealthy child cannot learn and that an uneducated child will become a drain on society has gained currency among all sectors of the health and education fields and led to the emergence of a range of collaborative undertakings. For example, at the federal level, the United States Department of Health and Human Services and the United States Department of Education recently issued their Joint Statement on School Health announcing their commitment to collaborate to achieve their mutual responsibility to the Nation's children. Likewise, localities across the country are recognizing the value of service integration, one-stop shopping and interdisciplinary service delivery teams — approaches for reaching the greatest number of children and families, with a comprehensive array of services, in the most cost-efficient manner. To make optimum use of the financial resources available at the federal level and the human resources available at the local level, state government is in a unique position to act as the nexus for collaboration.

For three years, the National Health & Education Consortium (NHEC) has worked to promote linkages between the health and education arenas at the state level. Recognizing that the governor plays a pivotal role in fostering collaboration, sponsoring cross-sector initiatives, championing interdisciplinary legislation and advocating stronger connections between programs, NHEC has worked through the governor's office in four pilot states — Florida, Maryland, New Mexico and Texas — to promote collaboration. *Putting Children First: State-Level Collaboration Between Education and Health* is a summary of our findings. What did we discover?

Most importantly, to promote real progress, state leaders must put children first. We must each move from being a teacher, a principal, a counselor, a pediatrician, a school nurse, a business leader, a legislator or a civic leader to being a child advocate. The needs of our respective professions must be secondary.

The four state-level health/education consortia discussed in this paper have commonalities that suggest essential ingredients of successful collaboration. Each state:

- formed a coordinating/planning committee;
- involved the business community;
- focused on the needs of the children of the state, not the needs of state agencies;
- coordinated a funding partnership; and
- held a conference or a series of conferences to engender interest in collaboration.

While there were commonalities in strategy, the National Health & Education Consortium supports a broad, adaptable framework for linking health and education services rather than a standard model to be imposed on existing state and local practices. NHEC's approach to promoting such frameworks recognizes the need for flexibility and makes use of collaborative partnerships at various tiers of policy-making. Using a combined "top-down" and "bottom-up" approach, NHEC encourages creating linkages at the national, state and local levels to promote better coordination and integration of services for children. This framework acknowledges that the state and local jurisdictions are well-positioned to assess their strengths and needs, to identify solutions to these needs and to take action to meet them.

NHEC's own experience at the national level lends further insight into appropriate action steps for developing state-level health/education consortia. In short, leaders interested in creating, merging or formalizing state consortia should:

1. ***Select leadership with political access***
   NHEC opted to work in every state in partnership with the office of the governor. Having the sanction/involvement of the governor or his/her staff gives the initiative the status and the entree necessary for program initiation, funding, maintenance and stability. However, the role of the state legislature should not be minimized. State legislators play a vital function in enabling cross-sector collaboration. It is very clear that the leader(s) of the collaborative must have access to the state power brokers in both the executive and the legislative branches of government.

2. ***Convene a formal steering committee***
A steering committee composed of health and education representatives enables consortia to develop an agenda that builds on the strengths of the two respective sectors as the group moves toward a shared goal. A diverse, influential steering committee will also ensure that a broad range of viewpoints are heard and will provide a stable base of continuity for the collaborative.

3. ***Build strong corporate involvement***
Involving the corporate community ensures that the mission of the collaborative is shared with and acted upon by those businesses and corporate leaders most able to help promote change in the state and its communities. In addition to a fresh perspective and strong resources, both human and financial, the involvement of business moves the initiative from the realm of human services to the more mainstream concern of what is fiscally responsible.

4. ***Develop a clear mission and goals and ensure accountability***
As the old saying goes, "If you don't know where you're going, any road will get you there." It is imperative that the steering committee have a sense of the education and health communities' respective strengths and needs as they develop a shared vision. Without this, the consortium cannot accurately identify the roles and responsibilities of both disciplines.

5. ***Build the public's awareness of the importance of linking health and education***
Those of us promoting collaboration often feel that everyone recognizes the value of pooling knowledge and resources. This is not the case. The need still exists to build awareness among not only the general public, but also among some segments of the education and health communities.

6. ***Promote grassroots interest and activities***
Having the support and active involvement of the Governor and his/her staff is invaluable, but a top-down only approach rarely can sustain itself. For a consortium to truly gain momentum, local leaders must be involved in developing the consortium's goals and objectives and in working to implement the identified strategies.

7. ***Capitalize on momentum***
We all want to be on the cutting edge, but we must also recognize the value of beginning wherever the community is. If the number one visible issue in the community is violence, it is an uphill battle for a consortium to decide to tackle nutrition as its first activity. The media will not follow its work. The attention of the political community will be elsewhere. The consortium will be swimming against the tide. A far better approach is to look for opportunities to connect what the consortium feels to be the pivotal issue to what the community is already focused on.

8. ***Maintain flexibility***
Rigidity is the deathknell of any organization. The consortium must be attuned to all of the factors that influence change in a community and be prepared to respond to those influences. For example, should a large number of immigrants suddenly enter a community, the needs of that community may shift and it is important to recognize these changes and be prepared to either respond or recognize that one's agenda may be temporarily placed on the proverbial backburner.

9. ***Evaluate the effectiveness of the initiative***
Vital to any group's continuation is the ability to assess what has worked, what hasn't and why and then to make adaptations based on the findings.

10. ***Seek core funding early***
Project-specific grants are an important source of seed or start-up money. Both federal and private foundation sources rarely provide support for ongoing work. If the work of the consortium is to continue as an established entity, financing for core activities must be actively sought. Far too often, we wait until the start-up money is almost gone before seeking other sources of sustained funding. Start early.

Introduction

The needs of our nation's children are complex, interrelated and increasingly diverse. Too often, children lack access to the people and services that address these needs. Many children lack adequate health care, housing, food or education; others lack the love and support of a nurturing environment. All of these needs, separately or in combination, influence children's health and their ability to learn.

Myriad agencies and organizations currently provide services to children to meet these needs. However, with alarming frequency, children's services and programs are fragmented — isolated from one another by mission, discipline and administration — and overly focused on the child as an individual client, rather than as part of an environment that includes family, school and community. Too often, children fall through the gaps. Without a strong safety net of primary and preventive health care and quality education, we are at risk of forfeiting our children's potential to be happy, healthy adults contributing fully to society.

Across the nation, many health providers, health educators and education professionals are beginning to discuss the impact of their respective disciplines and services on children's development. At the federal, state and local levels, decision makers in education and health are working strategically to identify and implement interdisciplinary solutions, given the complex needs of children and steadily shrinking resources.

This National Health & Education Consortium (NHEC) special report, *Putting Children First: State-Level Collaboration Between Education and Health*, is designed to serve as a resource for federal and state policy makers, leaders in health and education, and other professionals as they seek to work across disciplinary boundaries to create a more effective network of services for children. Because a state can leverage resources from three levels of government — local, state and federal — state leadership is able to create an environment that facilitates service integration. With such leadership, states can demonstrate success to the federal government and can act as harbingers of national reform.

It is the goal of this publication to elucidate why collaborative work must be undertaken, how collaboration can be effected and to what common ends health professionals and educators should work. More specifically, this report aims to:

- Provide case studies of existing NHEC state health/education consortia;
- Share NHEC's perspectives on the implications of state-level collaboration for the federal government; and
- Recommend action steps for developing and maintaining state health/education consortia.

As you review these case studies and recommendations for action, keep in mind this publication's primary message: put children first. If our ultimate goals are to ensure that children come to school ready to learn, not just in the first grade, but at every stage from pre-kindergarten through high school, and that we have an educated populace capable of making informed decisions that will lead to lifelong health, we must put the needs of children, not the needs of our respective professions, first. When we fully embrace the perspective that our primary mission is to put children first, we don't let the Medicaid forms become a deterrent, the school bus schedule is no longer an insurmountable barrier, the lack of funding for a school nurse will not mean no health services for the school. These factors will become the catalysts for collaboration among the health and education professions, catalysts for the integrated approaches to service delivery that do indeed put the child first.

Health/Education Consortia: Four Models

NHEC believes that effective changes in policies and programs at the state-level require commitment, leadership and support from policy makers — in particular from governors. As stated by the National Governors' Association in *Breaking Down the Barriers*, a governor is the "chief architect, chief executive and chief communicator" of a state's policy towards children and families. The governor has a pivotal role in setting the tone for collaboration, sponsoring cross-sector initiatives, championing interdisciplinary legislation and advocating for a better connection between the education and health communities. With the vision and leadership of the governors of Florida, Maryland, New Mexico and Texas, NHEC has assisted the development and work of state-level partnerships between the health and education sectors.

In partnership with the AT&T, Honeywell and Prudential Foundations, NHEC worked with these states to facilitate the development of state-level health and education collaboratives in order to (1) draw the attention of state policy makers to the inextricable link between the health and education sectors; (2) provide examples of ways that policy makers can develop and coordinate public policies, programs and delivery systems based on the critical interrelationship and interdependency of health and education; and (3) develop state health/education consortia that are able to expand and enhance the effectiveness of cross-agency/cross-sector collaboration.

Although there are a number of differences in the structure of the four initiatives, the planning used to create each show remarkable similarities. Each state:

- decided to form a coordinating/planning committee composed of a broad range of representatives from throughout the various spheres of the education and health communities[1];
- determined that inclusion of the business community was pivotal to ensure endorsement from those outside of the health and education spheres — an endorsement viewed as essential for long-term success;
- consciously agreed to discuss proposals in terms of what was in the best interest of children and families rather than from the narrow perspective of the needs of the respective agencies involved;
- coordinated a funding partnership from the national and state public sector as well as from the state and local private sector; and
- decided that a conference[2] or a series of conferences was a viable kick-off activity for promoting ongoing collaboration, for identifying the needs of the target population — the state's children — and for developing strategies for addressing those needs.

[1] Texas did not form a new group inasmuch as the Texas Comprehensive School Health Initiative already existed and was composed of the same representatives that were deemed pivotal to promoting a broad scope of health/education collaboration.

[2] Texas was already holding such an annual event. The "All's Well" conference was in its fourth year when Texas became one of the NHEC pilot states.

Florida

Governor Lawton Chiles has acted as co-chairman of NHEC since its inception and was the architect of the National Commission to Prevent Infant Mortality, one of NHEC's co-founders. Governor Chiles has a broad vision for Florida and clearly sees the advantages of vertically linking state-level efforts in health and education with those at the national and local levels, as well as the efficacy of fostering stronger ties horizontally at the state level between the health and education communities. As a primary stakeholder in designing service systems to improve the well-being of Florida's children and their families, Governor Chiles initiated an NHEC-supported health/education partnership in June 1992 and invited Florida's Education Commissioner, Betty Castor, to serve with him as the partnership's co-chair.

The creation of the Florida Health/Education Consortium (FHEC) followed the passage of the state's Joint Interagency Agreement between the Department of Education and the Department of Health and Rehabilitative Services, an agreement that provided a timely foundation for much of the state health/education consortium's planning. This interagency agreement specifies that the two agencies will collaborate on all matters relating to school health, the implementation of targeted legis-

lation (P.L. 99-457) for children from birth to five years, dropout prevention, developmentally appropriate day care for the children of teen parents, AIDS, public/private partnerships, and parent education and involvement programs. Accordingly, Governor Chiles and Commissioner Castor saw the development of a state-level consortium as a mechanism for furthering their children's agenda and for enhancing their efforts to bring together state leadership in the arenas of health and education.

Once FHEC was formed, a 27-member steering committee was created to lend its expertise to overseeing the initiative (see Appendix C). Membership on this steering committee included representatives from state health and education agencies who hold leadership positions within their departments, professional organizations and community-based organizations. Leadership from the business community was provided through representation from the corporate headquarters of AT&T Florida and the Ryder Foundation.

FHEC chose as its mission the development of strategies for promoting comprehensive school health services. A kick-off state-wide forum, "Making the Grade Starts with a Healthy Child" held on June 24, 1992 in St. Petersburg, Florida, attracted well over 300 participants including health providers, educators, community representatives, business leaders, state and local government officials, media professionals and parents. Immediately following the conference, the steering committee of FHEC met to begin identifying opportunities to integrate the consortium's activities into other state-wide efforts that promote school health; collaboration would maximize FHEC's effectiveness and minimize the potential for unnecessary duplication of efforts.

The FHEC steering committee also made preliminary plans to hold a three-day planning retreat. The purpose of this retreat was to develop a state-wide plan for school-based and school-linked services and to generate a state-wide information campaign. This campaign would be designed to heighten awareness among state legislators, school professionals, health providers and parents of the inextricable links between children's health and their ability to learn.

Although Florida's consortium is now in its third year of operation, it encountered a few unanticipated obstacles that have hampered its efforts toward state-wide impact. The devastating landfall of Hurricane Andrew tremendously diverted the activities of not only FHEC, but of the entire state. The hurricane's widespread effects — the destruction of homes, businesses, schools and community organizations — necessitated a re-prioritization of initiatives, both for state leadership and the citizens throughout Florida. This tragedy highlighted the fragility of cross-sector collaboration in the face of natural disaster — a fact that has subsequently been revealed in a number of states across the nation.

Due to Hurricane Andrew and its aftermath, the Governor's office was forced to focus its attention on issues other than FHEC; however, interest in collaboration was still alive in other sectors of state government. The overall agenda of FHEC had been to generally promote linkages between the health and education communities. Planning had not moved to the specifics of how this was to occur.

During the lapse in activity following Hurricane Andrew, the Executive Director of the Comprehensive School Health Program of the Florida Department of Education and the Executive Director of the Comprehensive School Health Program of the Florida Department of Health and Rehabilitative Services jointly attended a 1993 Centers for Disease Control and Prevention-sponsored conference to promote state collaboration around health education and services in the school. There the nucleus of an idea emerged to form a health and education collaborative group committed specifically to comprehensive school health education and services. Thus emerged a sister consortium to the one previously formed by the Governor.

On September 19-20, 1994, these two groups came together for the first time for a joint planning meeting (see Appendix C for agenda). By the end of the event, both consortia had decided to merge into a unified state-wide consortium that draws on

the expertise and influence of the Governor's office, the State Departments of Education and Health and Rehabilitative Services, local leaders and the business community. Two additional meetings of the new *Florida Health/Education Consortium* are planned for 1995.

The Florida experience is a valuable one. While Governor Chiles' involvement was critical to generating the political will and the official state sanction for a collaborative, the other demands of the state precluded his ongoing focused attention. However, Governor Chiles was known to be committed to grassroots initiatives and local involvement in governance. Therefore, because formal gubernatorial approval had been given for health/education collaboration, when staff of the two key state agencies were energized to form a collaborative, the heads of their agencies were supportive because they knew that the Governor was already behind such a relationship. Florida teaches us that while trickle down strategies from the top level of government play an important role, having the Governor's support in tandem with more grassroots, staff-generated interest is a powerful and effective combination.

For additional information on the work of the Florida Consortium, please contact Ms. Julia Pallentino, Executive Director, Comprehensive School Health Program, Florida Department of Health and Rehabilitative Services, 325 West Gaines Street, Room 414, Tallahassee, FL, 32399-0400; or Executive Director (at press time, this position was vacant), Florida Department of Education, Comprehensive School Health Program, 1317 Winewood Boulevard - HSFHP, Tallahassee, FL, 32399-0700.

Maryland

Since his election, Maryland Governor William Donald Schaefer made prevention a major focus of his Administration. He provided leadership in the design of a comprehensive package of health initiatives that not only included prevention but also placed an emphasis on building public/private partnerships. Combining these two areas of interest, the Governor initiated the planning process for the establishment of the Maryland Health/Education Consortium (MHEC). He was assisted in this effort by his Executive Assistant for Health.

The Maryland Health/Education Consortium took shape during the first half of 1993 as a result of the Governor's decision to conduct a state-wide forum on the health/education connection and its implications for Maryland. A small planning committee of agency officials and organizational leaders was convened (see Appendix D), and it was decided that an infrastructure for ongoing activities should be created that could serve not only as the umbrella entity within the Governor's office for planning the forum but also assist in future collaborative activities in the areas of health and education.

The planning committee adopted the following vision and mission statements for the consortium:

Vision: Maryland will have a service delivery system that offers all families the services and assistance they need to prevent or minimize health problems and to promote the development — physically, mentally and emotionally — of children, youth and families. This system will be located within communities, involve public and private partners, be family-focused, and recognize and respect diverse ethnic and cultural strengths and needs.

Mission: The Maryland Health/Education Consortium will promote this vision through:

- Coordination of current health/education models in the state that offer services and assistance to children and families;
- Advocacy for the development of public/private partnerships at the community level to support comprehensive community school-based or school-linked health services for Maryland children birth through eighteen years old and their families; and
- Advocacy for comprehensive school health programs which encompass all instructional and support services programs that assist students and their families in achieving a high level of wellness.

Following the creation of the vision and mission statements, the Governor and the planning committee decided to hold an invitational Governor's Summit on "School-Linked Health Services for Children and their Families." The purpose of the Governor's Summit was to share the latest thinking on school-based/school-linked health services at the state and federal levels with a focus on how to develop, finance and sustain successful models.

Held in November 1993, the Governor's Summit served to launch the formal activity of MHEC. Some 1,000 invitations were extended to business and community leaders, parents, students, and education and health professionals. Half of those invited attended the conference, which featured a variety of speakers (notably U.S. Surgeon General Joycelyn Elders) and a series of concurrent forums on the linkages between health and education.

Almost one year later, on October 13, 1994 a second Governor's Summit on School-Linked Health Services for Children and Families, entitled "Healthy Families, Healthy Schools: A Call To Action," was held at the University of Maryland, College Park (see Appendix D for agenda). This conference continued the mission of providing education and information on the purpose, structure and financing of a school-linked system to local educators, health professionals, administrators and parents.

The Planning Committee is now designing a structure and financing mechanism to permanently establish MHEC in the Governor's Office. The Committee is laying the groundwork for the eventual institutionalization of the consortium via a Governor's Executive Order.

In this decision lies an important lesson. Governor Schaefer had been committed to this initiative, but 1994 was an election year and Maryland's Constitution prohibited the Governor from seeking a third consecutive term. The groundwork for an Executive Order had been laid with an Administration that was in its waning days. However, the Maryland Planning Committee had another route to political access, its chair, the Governor's Executive Assistant for Health, ran for and won seat in the Maryland House of Delegates. The Maryland group had recognized the need to bridge both the executive and legislative branches of government.

For additional information on the work of the Maryland Consortium, please contact The Honorable Marilyn Goldwater, Member, Maryland House of Delegates, 5508 Durbin Road, Bethesda, MD 20814.

New Mexico

Since 1991, New Mexico has experienced a paradigm shift in its approach to providing services to children. When Governor Bruce King returned to office in 1990, after an eight-year absence, he discovered that the status of children in New Mexico had deteriorated significantly during the 1980's. A relatively poor and primarily rural state, with a majority of its children members of minority groups, the state ranked nationally in the lower decile in terms of prenatal care, insurance coverage for children, and school graduation rates, and was in the top decile for youth violence.

In response to these problems, the Governor and Mrs. King established the Governor's Task Force on Children and Families, composed of the four Cabinet Secretaries whose departments have major responsibility for children's programs, the State Superintendent of Public Instruction, community-based service providers and children's advocates. The Task Force was representative of New Mexico's geographic, ethnic and cultural diversity. Chaired by the First Lady and staffed with support from a legislative appropriation, the committee met intensively from April 1991, through January 1992, holding town meetings throughout the state and conducting policy deliberations at the Governor's Mansion. These deliberations, in turn, led the Task Force to develop a set of recommendations for collaborative action which led to the establishment of the New Mexico Health/Education Consortium (NMHEC).

NMHEC activities have been led by a team representing three agencies of state government, composed of the Health Education consultant for the State Department of Education, the Director of the Maternal and Child Health Bureau in the Department of Health, and the senior staff member in the Governor's Office responsible for education and children's issues (see Appendix E).

The team's first decision — how to go about approaching its state-wide activities — has been key to the shape and success of the project. The NMHEC team decided to focus on local decision-making, facilitated by a series of regional conferences, rather than on a statewide conference or state-level publications.

The first of the Consortium's regional conferences was held in June 1992, and targeted the southern section of the state, which borders Mexico. School districts and communities in this area face multiple and unique challenges, many of which result from the nearly 200 mile long international border, crossed by thousands of people (and hundreds of school-age children) each day. In the area, housing enclaves called "colonias" have sprung up to house immigrant and migrant workers. Most of the colonias are without adequate water supply, sewage systems or other basic services. The school-age populations in colonias are expanding rapidly, placing great demands on the local school districts; border area schools provide an education to all children who come to their doors — proof of citizenship is not required. In addition to U.S.-based migrant families, a significant number of children walk across the border, or are driven across, to school each day. Health services, like education, are provided without a requirement for citizenship documentation.

The border area conference, "School and Community: Solving Health Problems Together" was held in Las Cruces over two days. This regional conference was the first time these border communities had an opportunity to engage in a formal planning process geared toward state-level collaborative change. The conference goal was articulated by First Lady Alice King, who challenged community groups to develop practical and attainable action plans for their communities. To ensure true community representation at the conference, the meeting planning team contacted the school superintendents in each local district to ask them to establish a district steering committee, composed of educators, health providers and the general public. Each of these groups in turn selected the conference invitees from their area.

In addition to developing action plans, the conference was devoted to encouraging community teams to continue to meet. Trained facilitators, whose time was donated by their local businesses or agencies, assisted each group with identifying needed actions, setting realistic timeta-

bles, and assigning responsibilities. Participants stressed that the role of the facilitator was key to the success of their planning strategy.

Using this successful experience as a template, NMHEC next tackled the challenge of conducting a similar conference for 11 school district communities in the middle Rio Grande area of the state. The Rio Grande area school districts serve more than 45% of the school children in the state, and the districts are very diverse. The Albuquerque area has an abundant supply of health providers and community-based organizations; the Magdalena community has, literally, no health providers. From ranching communities to mountain districts to rapidly growing suburban areas, each community faces its own challenges and opportunities. And never, until the NMHEC Conference in January 1993, had these communities had the opportunity to bring together their educators, health providers and leading citizens to assess their own strengths and to address their own needs.

During the closing plenary session of the Rio Grande conference, each community reported its plan of action. Like the communities themselves, the plans were very diverse, some focusing on mental health and violence issues, others on coordinating and increasing accessibility of services. Two neighboring school districts in growing areas south of Albuquerque decided that they needed to work together and joined forces for the meeting's second planning session. The spirit of the conference was exemplified by the team from Estancia which closed the session by setting themselves in a line, each holding a large hand-made placard. At a signal, each turned over his or her placard to form a banner of sorts reading "JUST DO IT!"

An additional similar kick-off regional conference for the state's east side has been held and one year follow-up conferences have been held by the first two groups of meeting participants. In order to complement the regional kick-off and follow-up conferences in the eastern, southern and middle areas of the state, NMHEC hosted a conference for northern New Mexico in October, 1994 (see Appendix E for agenda).

The regional orientation of NMHEC's *conferences exemplifies one of the primary themes of* Governor King's "New Mexico's Children's Agenda" — *local decision-making. Given the opportunity, communities will identify significantly differing strengths and needs and varying strategies to meet those needs. However, while community plans are very diverse in nature, certain common threads exist. Many groups at the* NMHEC *conference identified the need for school-based health services. The need for good, healthy after-school activities open to all young people was frequently stated. Even relatively small communities discovered new resources, and ways of working together to enhance those resources that had not previously been identified.* New Mexico *has seen the enthusiasm generated by local empowerment and has seen that "turf" issues can be overcome. The* NMHEC *experience has strengthened the state's determination to use local empowerment strategies to address many additional issues in state government.*

Because of the strong ties with Governor *and* Mrs. King, NMHEC *may encounter some changes inasmuch as the* Governor *was not re-elected. There is strong leadership from both the state education and health agencies. New Mexico is still a state to watch.*

For additional information on the New Mexico Consortium, please contact Ann Taulbee, Bureau Chief, MCH, Department of Health, New Mexico Department of Health, Harold Runnels Building, 1190 St. Frances Drive, Santa Fe, NM, 87503; or William Blair, PhD, Consultant for School Health Programs, State Department of Education, Education Building, 300 Don Gaspar, Santa Fe, NM, 87501-2786.

Texas

Unlike the National Health & Education Consortium's other state-level collaborative models, impetus for the Texas Health/Education Consortium did not initially emerge as the result of a Governor's initiative. Rather, it evolved as an outgrowth of an independent entity established three years prior to NHEC's involvement and composed of 30 health and education agencies and associations, with an 11-member Board of Directors (see Appendix F). This entity, called the Texas Comprehensive School Health Initiative (TCSHI), represents the state's comprehensive school health initiative and works with NHEC to foster state-level health and education collaboration, with the support of the Governor.

TCSHI began in 1989 as a partnership project between the Texas Association of School Administrators (TASA) and the Texas Center for Comprehensive School Health. With the assistance of a three-year grant from the U.S. Department of Education (DOE), TCSHI evolved into a broad consortium of health and education organizations with a mission "to enhance and promote the health and well-being of Texas children, youth and their families through a collaborative effort between health and education organizations and Texas schools." TCSHI's work was in jeopardy in 1992 when its federal DOE grant ended. It was at that time, in partnership with the AT&T Foundation, that NHEC made a two-year grant available to TCSHI to support its state-level health/education collaboration activities.

In Texas, the work of the National Health & Education Consortium occurs through TCSHI. This group was established and had name recognition. It was not deemed important to establish a new group under the name, "Texas Health and Education Consortium," but more important to support a group with a very similar mission whose existence was threatened by the end of federal funding.

In November 1993, TCSHI sponsored a state-wide forum on health and education, the "Texas School Health Summit: Working Together for the Future," held in Conroe, Texas (see Appendix F for agenda). The format of the Summit was modeled after a 1992 national conference conducted by the American Cancer Society. Its agenda called for the on-site development of a state-wide plan for comprehensive school health education and services. Over the course of three days, a series of six working sessions were conducted in which participants wrote the plan, focusing on policy; awareness; parent, family and community involvement; educational and health outcomes and standards; professional preparation and practice; and resources. This plan guides the work of the TCSHI.

TCSHI's history is longer than that of any of the other state health/education consortia. Its work is focused in five broad areas: legislative briefings; statewide activities to improve school-based/school-linked services; statewide campaigns in support of comprehensive school health programming; conferences; and public policy. To support state-level collaboration, TCSHI has sponsored invitational conferences, hosted strategic planning forums, assisted with the development of needs assessment instruments to evaluate the adequacy of existing comprehensive school health programs, developed standards for what constitutes a comprehensive school health program, and worked with school district leaders to adopt the standards as guidelines for planning and development. Recently TCSHI and its 30 plus member agencies/associations adopted policy statements. Recognizing that the consortium, due to its diverse membership, may find it difficult to agree on positions on specific bills during the upcoming legislative session, it was decided to develop position statements on broad items such as school health instruction, school food service and counseling and guidance services. These statements will serve to advise legislators of TCSHI's general positions without compromising the individual needs of the members of any one of the TCSHI member associations.

Recommendations for Developing a Health/Education Consortium

Texas' experience shows what is possible after five years of cohesive existence. TCSHI *is well entrenched at the state level. It is viewed as a leader for school health services and education by both education and health policy makers and program administrators, and by the political leaders of the state. It has developed an effective method of coalescing without jeopardizing the needs of individual member groups of the association.* TCSHI *has contributed to positive change in the health/education landscape in Texas, but its leaders still acknowledge important obstacles to success: the size of the state, the diversity of the state's population, and the lack of ongoing core funding for the work of* TCSHI.

For additional information on the work of the Texas Comprehensive School Health Initiative, please contact Judy Jonas, Project Director, c/o Texas Association of School Administrators, 406 East 11th Street, Austin, TX 78701-6361.

Each of the four state-level health/education consortia discussed in this paper have commonalities that offer an outline of essential ingredients to successful collaboration. In combination with NHEC's experience at the national level, these commonalities point toward ten action steps necessary for developing successful state-level health/education consortia.* Leaders interested in creating, merging or formalizing state consortia should:

1. ***Select leadership with political access***
   NHEC opted to work in every state in partnership with the office of the governor. Having the sanction/involvement of the governor or his/her staff gives the initiative the status and the entree necessary for program initiation, funding, maintenance and stability. However, the role of the state legislature should not be minimized. State legislators play a vital function in enabling cross-sector collaboration. It is very clear that the leader(s) of the collaborative must have access to the state power brokers in both the executive and the legislative branches of government.

2. ***Convene a formal steering committee***
   A steering committee composed of health and education representatives enables consortia to develop an agenda that builds on the strengths of the two respective sectors as the group moves toward a shared goal. A diverse, influential steering committee will also ensure that a broad range of viewpoints are heard and will provide a stable base of continuity for the collaborative.

3. ***Build strong corporate involvement***
   Involving the corporate community ensures that the mission of the collaborative is shared with and acted upon by those businesses and corporate leaders most able to help promote change in the state and its communities. In addition to a fresh perspective and strong resources, both human and financial, the involvement of business moves the initiative from the realm of human services to the more mainstream concern of what is fiscally responsible.

4. ***Develop a clear mission and goals and ensure accountability***
   As the old saying goes, "If you don't know where you're going, any road will get you there." It is imperative that the steering committee have a sense of the state's education and health communities' respective strengths and needs as they develop a shared vision. Without this, the consortia cannot accurately identify the roles and responsibilities of both disciplines.

5. ***Build the public's awareness of the importance of linking health and education***
Those of us promoting collaboration often feel that everyone recognizes the value of pooling knowledge and resources. This is not the case. The need still exists to build awareness among not only the general public, but also among some segments of the education and health communities.

6. ***Promote grassroots interest and activities***
Having the support and active involvement of the Governor and his/her staff is invaluable, but a top-down only approach rarely can sustain itself. For a consortium to truly gain momentum, local leaders must be involved in developing the consortium's goals and objectives and in working to implement the identified strategies.

7. ***Capitalize on momentum***
We all want to be on the cutting edge, but we must also recognize the value of beginning wherever the community is. If the number one visible issue in the community is violence, it is an uphill battle for a consortium to decide to tackle nutrition as its first activity. The media will not follow its work. The attention of the political community will be elsewhere. The consortium will be swimming against the tide. A far better approach is to look for opportunities to connect what the consortium feels to be the pivotal issue to what the community is already focused on.

8. ***Maintain flexibility***
Rigidity is the deathknell of any organization. The consortium must be attuned to all of the factors that influence change in a community and be prepared to respond to those influences. For example, should a large number of immigrants suddenly enter a community, the needs of that community may shift and it is important to recognize these changes and be prepared to either respond or recognize that your agenda may be temporarily placed on the proverbial backburner.

9. ***Evaluate the effectiveness of the initiative***
Vital to any group's continuation is the ability to assess what has worked, what hasn't and why and then to make adaptations based on the findings.

10. ***Seek core funding early***
Project-specific grants are an important source of seed or start-up money. Both federal and private foundation sources rarely provide support for ongoing work. If the work of the consortium is to continue as an established entity, financing for core activities must be actively sought. Far too often, we wait until the start-up money is almost gone before seeking other sources of sustained funding. Start early.

Based on NHEC's experience with state-wide health/education collaboratives, the Consortium contends that efforts at the federal and state levels must occur simultaneously if broad-based system change is to occur. Specifically, expanded federal support of collaboration would provide the "top down" stimulus and environment for "bottom-up" planning and delivery of children's services at the state level.

The federal government's efforts should include seeking opportunities to reallocate resources, facilitate interagency partnerships, dissolve incongruent policies, identify creative financing mechanisms, and cultivate an environment supportive of broad-based collaborative action. Interagency agreements, memoranda of understanding, mergers/consolidations, collaborative service ventures, joint planning of program budgets, co-location of services, reallocation of fiscal resources and redistribution of physical resources are some of the approaches that can be implemented.

The federal government has already begun to demonstrate its support of health/education collaboration. Most notably:

The U.S. Departments of Health and Human Services and Education recently signed a Joint Statement on School Health.

Two interagency committees, co-chaired by representatives of the two departments, the Interagency Committee on School Health (ICSH) and the National Coordinating Committee on School Health (NCCSH) have been established to coordinate efforts. ICSH is composed of representatives from nine federal departments and agencies. NCCSH is composed of non-governmental health and education organizations and advises ICSH.

The recently reauthorized Elementary and Secondary Education Act includes funds to promote coordinated services and, due to involvement from the health community, includes an anti-smoking measure.

Selected states have been granted waivers from both Departments to enable the co-mingling of funds originally earmarked for drug prevention, AIDS prevention, etc.

The Centers for Disease Control and Prevention has provided funding to support a senior policy position in the office of the state school superintendent and a similar position in the office of the state health commissioner in selected demonstration states to foster cross-agency collaboration.

There was significant collaboration between the Department of Education and the Department of Health and Human Services in the development of the Administration's health reform proposal particularly around efforts to designate some funding as non-categorical.

Anecdotal information suggests that cooperative planning extends far beyond specific pieces of legislation. When asked about the growing coordination of services between the Departments of Education and Health and Human Services, one senior-level Administration official noted, "Great change has occurred. A few years ago [it would have seemed] that they [DOE and HHS] were working for different governments."

NHEC suggests that the federal role in promoting and enabling health and education collaboration should encompass, at least, the following:

- Promote the concept of collaboration in the executive and legislative branches;
- Experiment with ways to enable states and localities to blend multiple funding streams that serve largely the same populations through, for example, waivers or increased flexibility in the use of funds. Currently, small pools of federal funds provide support for prevention efforts under a number of different headings, thereby diluting jurisdictions' ability to develop a strong initiative with substantive funding.
- Simplify current programs by, for example, using similar definitions, eligibility criteria, application processes and reporting forms. Combine multiple programs to increase their impact and reduce administrative costs.
- Use common computer technology to assist in case tracking, research and reporting, data compilation, and the processing of joint applications. As the system currently works, beneficiaries complete numerous forms requiring similar information to determine eligibility of services. Often, persons applying for benefits are overwhelmed by the very process itself. Computer technology can help make application processes less cumbersome and complex, tracking those who have already applied for benefits and providing ready access to information about clients' eligibility status. The latter would be instrumental in expediting enrollment. Computer technology can help develop databases necessary to measure outcomes, system efficiency and effectiveness, and impact. Consistent technology would be an important step in ensur-

ing accountability and developing evaluation measures.

- Establish a Children, Youth and Families Council consisting of the Secretaries of the heads of the Executive Branch departments that most affect children and families. Such a council could provide leadership for cross-sector activity, identify and eliminate programmatic policy barriers, champion changes in eligibility requirements and definitions, establish collaborative outcomes, and identify national problems that go beyond the coordination of existing programs.

- Develop evaluation and auditing measures that focus on clear outcomes and results, not just process. Such information would shift the focus from who did what to the more important issue of what was the result of the intervention.

Last, but certainly not least, is the notion of evaluation/accountability. It is essential during both the development and implementation of any state-level collaborative initiative that benchmarks for success be established and used as touchstones for assessing progress and remaining on track. This is especially true during an era of limited fiscal resources. Just as it is imperative to have short- and long-range measures of success for any policy or program, it is critical to the credibility of state collaborative action that tangible progress and results be identifiable. Policy makers will rely heavily on demonstrable results as they prioritize spending in a financial environment of limited public monies and increasingly competitive concerns. Suggested process outcome measures for state-level health/education consortia include:

- ***Development of a community action plan to collaborate for effective services and policies.*** Are more communities becoming involved in the planning process for service integration and collaboration at both the state and community levels? Do community action plans include detailed action steps and benchmarks for accomplishing the tasks in the plan?

- ***Existence of collaborative projects.*** Collaborative activity is the fruition of convening and awareness-building. Are there any collaborative projects in existence? If so, how long have they existed? What is their purpose? Can they serve as a foundation for other collaborative work? Who are the key players? What plans have been developed? What results have been achieved?

- ***Formalization of the health/education consortium.*** Is there a mechanism in place for building consensus and collaboration? How is collaboration taking place? How visible are the consortium's efforts? Where does the consortium's leadership come from — does it represent the entire community? Have governance and long-term management and decision-making issues been addressed?

- ***Greater awareness of the health/education connection and its importance.*** Has there been improvement in awareness of the link between health and education among health professionals, educators, parents and others? Is there an increase in the level of collaboration between health and education professionals? Are people talking more about the need to prevent/curtail duplication so that resources can be reallocated and shared?

- ***Existence of legislative or administrative tools that support health/education collaboration.*** Is there a state-level commitment to support health/education collaboration activities? Has an executive order, proclamation, interagency agreement or reallocation of funds or resources been implemented?

- ***Greater public and private investment in children's health and education.*** Is there more funding for health/education collaboration? Has there been an increase in investment for school-based or -linked services? Are responsible public agencies and private providers maximizing the coordination of their monies?

Ultimately, of course, product outcome measures are necessary to evaluate the success of long-term collaborative activity. As Lisbeth Schorr and her colleagues at the Harvard Project on Effective Services have noted, using outcomes assessment as a measure of collaborative reform success gives rise to the varied feelings of hope, fear and confusion:

> **Hope** that outcome-based accountability could be the key to freeing schools, health care, social agencies and other human services from the rules that prevent them from operating flexibly in response to the needs of those they serve; and restoring the public's faith that both public and private human service institutions can accomplish their intended purpose.
>
> **Fear** that outcome accountability will be misused and result in the abandonment of attempts to better the conditions of disadvantaged children whose effects are difficult to measure or take a long time to occur; the erosion of essential procedural protections and neglect of concerns for equity; excuses for further funding cutbacks; or in penalizing individual professionals, institutions and agencies who may not be achieving hoped-for results, but are trying hard and doing the best they can.
>
> ***Confusion*** about how to devise and obtain agreement on a set of crucial outcomes and reliable ways of measuring results that could justify the hopes and quell the fears of the many concerned constituencies.[3]

Basic outcome goals will help alleviate fears, minimize confusion and capitalize on hope and energy. Suggested outcome-based accountability measurement for state-level health/education collaboration should include at a minimum the following goal:

> ***Changes in health and education status and behavioral choices.*** Have any improvements been made in the health and educational status of children and/or their behavioral choices? If so, what? For example, are children entering school better prepared to learn? What impact has the collaborative had on health status indicators? Is the school absenteeism rate declining? Are there fewer high school dropouts? Are there higher standardized proficiency scores? Has the cost of remedial education decreased? Are existing health screening, referral and care options being better utilized?

[3] Schorr, Lisbeth et al. "Shifting to Outcome-Based Accountability: A Minimalist Approach For Immediate Use" (Working Draft). Washington, DC: National Alliance for Restructuring Education. 1994.

Conclusion

The National Health & Education Consortium supports a broad, adaptable framework for linking health and education services. NHEC's approach to promoting the success of such frameworks by fostering collaboration and leveraging state-level resources for children recognizes the need for diversity and encompasses the use of collaborative partnerships at various tiers of policy-making. Using a combined "top-down" and "bottom-up" approach, NHEC encourages creating linkages at the national, state and local levels that promote better coordination and integration of services for children. This framework acknowledges and maximizes the concept that state and local jurisdictions are well-positioned to assess their strengths and needs, to identify solutions to these needs and to take action to meet them.

Through briefings, special forums, technical assistance activities and publications/information dissemination, NHEC has assisted four states in forming collaborative health/education partnerships. While the state models vary in structure and operations, their underlying mission is the same — improvement of planning and programs for school and health services.

Cross-disciplinary activity is mushrooming in this country. Only a few years ago, there were but a handful of states involved in this movement; now, it is easier to list the states that are not. Ironically, however, the same demands and challenges that have encouraged cross-sector discussion and highlighted the related concerns of children act to limit successful, long-term collaboration. Lack of common understanding, language barriers, differing viewpoints and missions, and a competitive financing environment place severe strains on existing programs and the possibility of long-term interdisciplinary endeavors. The first few years of this decade have witnessed a dra-

matic increase in interest regarding broad cross-sector planning and action for health and education system reform. Proactive leadership is evident in many states, and a number of jurisdictions have already begun to plan, develop and implement system-wide reform.

We hope that this publication has given you a sense of the importance of state-level collaboration between the arenas of health and education. It has been our goal to explain why cooperative work must be undertaken, how collaboration can be effected, and to what common ends health professionals and educators should work. The National Health & Education Consortium, with the AT&T Foundation, the Honeywell Foundation and the Prudential Foundation has partnered with top leadership in four states to bring together those who serve children through policy and service, and to provide examples for other states to consider. NHEC encourages you to consider their activities and our recommendations in the light of your state's strengths and needs. But, whatever you glean from this publication, please take this message with you and share it with your colleagues: state-wide partnerships for change are a promising vehicle for engaging the talent and spirit of the energetic men and women who serve our young citizens and community members. Sharing experiences, learning to understand common missions and working together will bring the fields of education and health, and the policy and corporate sectors, to one table around a single mission: improving how we serve our most valuable resource — our children.

Appendices

Appendix A

Selected Collaboration Resources[1]

Barriers to Developing Comprehensive and Effective Youth Services
American Youth Work Center
1751 N Street, NW • Suite 302
Washington, DC 20036
(202) 785-0764

Children, Families and Communities
The Chapin Hall Center for Children
University of Chicago
1155 East 60th Street
Chicago, IL 60637
(312) 753-5900

Collaboration: What Makes It Work
Amherst H. Wilder Foundation
Management Support Services
919 Lafond Avenue
St. Paul, MN 55104
(612) 642-4025

Collaboration Handbook: Creating, Sustaining and Enjoying the Journey
Amherst H. Wilder Foundation
Publishing Center
919 Lafond Avenue
St. Paul, MN 55104
(800) 274-6024

Community Collaboration Manual
National Assembly — National
Collaboration for Youth
1319 F Street, NW • Suite 601
Washington, DC 20004
(202) 347-2080

Fairness Is A Kid's Game
Kentucky Youth Advocates, Inc.
2034 Frankfort Avenue
Louisville, KY 40206
(502) 895-8167

Together We Can: A Guide For Crafting A Profamily System of Education and Human Services
United States Departments of Education
& Health and Human Services
U.S. Government Printing Office
Superintendent of Documents
Mail Stop SSOP
Washington, DC 20402-9328

[1] Listing in part from "Some Collaborative Resources," *Youth Today*, September/October, 1994, Vol. 3, No. 5, p. 23. Used with permission.

Appendix B

NATIONAL HEALTH & EDUCATION CONSORTIUM (NHEC) FOUNDING ORGANIZATIONS AND ROSTER OF MEMBERS

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

The National Commission to Prevent Infant Mortality was formed by Congress in 1987 to create a national plan to reduce infant mortality and morbidity in the United States. The sixteen-member Commission, chaired by Governor Lawton Chiles of Florida, included Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives of state government, and experts in the field of maternal and child health. The Commission closed its doors at the end of the 1993.

THE INSTITUTE FOR EDUCATIONAL LEADERSHIP

The Institute for Educational Leadership, whose activity dates back to 1964, began as an Institute of the George Washington University and became an independent, non-profit organization in 1981. The Institute for Educational Leadership's stock-in-trade is ongoing leadership programs operating in Washington, D.C. and more than 40 states. These programs help decision-makers to understand and more effectively address significant educational policy issues.

The Institute for Educational Leadership, while anchored in the field of education, has broadened its activities to other policy and service arenas which affect schools with increasing frequency and importance. Because it does not have a single membership base, the Institute for Educational Leadership is particularly well positioned to use its convening capacities to serve as a broker bridging the gap between schools and related fields. The Institute for Educational Leadership is chaired by James J. Renier, retired CEO and Chairman, Honeywell.

NHEC Membership

American Academy of Family Physicians: represents 71,000 family physicians

American Academy of Pediatrics: represents 45,000 pediatricians

American Association of Colleges for Teacher Education: represents 706 member institutions' teacher education programs

American Association of School Administrators: represents 18,517 school administrators

American College of Nurse-Midwives: represents 3,500 practicing nurse-midwives

American College of Obstetricians and Gynecologists: represents 31,000 obstetricians and gynecologists

American Dental Association: represents 140,000 dentists

American Federation of Teachers: represents 750,000 teachers, paraprofessionals (teacher aides), school-related personnel, health-care workers, federal and state employees

American Hospital Association: represents 5,870 hospitals and over 50,000 physicians

American Indian Health Care Association: represents 36 programs and clinics which focus on the health care of American Indians

American Medical Association: represents 300,000 physicians

American Nurses Association: represents 201,000 registered nurses

American Psychological Association: represents 118,000 clinicians, researchers, educators, consultants and students

American Public Health Association: represents 30,977 physicians, nurses, therapists, health technicians, health support personnel, and other health professionals.

American School Food Service Association: represents 65,000 child nutrition and school food service employees

American School Health Association: represents 4,100 health educators, nurses, physicians and dieticians

American Speech-Language-Hearing Association: represents 74,000 audiologists and speech-language pathologists

Association for the Care of Children's Health: represents 4,200 health care providers, and parent leaders

Association for Supervision and Curriculum Development: represents 153,000 teachers, school administrators, college professors and school board members

Association of American Medical Colleges: represents 126 U.S. medical schools, 450 teaching hospitals, and 94 academic professional societies

Association of Maternal and Child Health Programs: represents 269 Maternal and Child Health Program directors and staff.

Association of Schools of Public Health: represents 14,500 faculty and students at 26 certified schools of public health

Association of State and Territorial Dental Directors: represents 44 state dental directors nationwide

Association of State and Territorial Health Officials: represents 58 health officers from each of the United States and its territories

Association of Women's Health, Obstetric, and Neonatal Nurses: represents 24,700 nurses

Council of Chief State School Officers: represents 56 public officials who head departments of elementary and secondary education in each state and extrastate jurisdiction

Council of The Great City Schools: represents 47 of the largest urban public school districts in the United States

Healthy Mothers, Healthy Babies Coalition: represents 95 non-profit health education groups, and state and local education groups

National Alliance of Black School Educators: represents 4,000 African-American teachers for grades K-12

National Association for Asian & Pacific American Education: represents approximately 500 educators concerned for the educational well-being of Asian and Pacific American students

National Association for the Education of Young Children: represents nearly 77,000 professionals and others who study or are interested in childhood education and development

National Association of Children's Hospitals and Related Institutions: represents 108 hospitals

National Association of Community Health Centers: represents 600 health care facilities

National Association of Elementary School Principals: represents 26,000 elementary and middle school principals in the U.S., Canada and overseas

National Association of Hispanic Nurses: represents 1,000 Hispanic nurses

National Association of Partners in Education: represents 5,500 volunteers, presidents and executives of private businesses, teachers and administrators

National Association of Pediatric Nurse Associates and Practitioners: represents 4,200 pediatric nurse associates and practitioners

National Association of School Nurses, Inc.: represents 8,000 school nurses

National Association of Secondary School Principals: represents 41,000 secondary school principals, administrators, guidance counselors, activities directors and college professors

National Association of Social Workers, Inc.: represents 145,000 professionals and para-professionals in the field of social work

National Association of State Boards of Education: represents 600 state boards of education and their members

National Association of State School Nurse Consultants: represents 35 registered nurses employed at the state level in departments of education and/or health

National Association of WIC Directors: represents 624 state directors, nutrition coordinators, and local agency directors

National Black Nurses' Association: represents 7,000 African-American nurses

National Coalition of Hispanic Health and Human Services Organizations (COSSMHO): represents 12,000 organizations serving the Hispanic population, representing Hispanic physicians, nurses and students

National Community Education Association: represents 1,550 teachers, superintendents, administrators, community education directors and coordinators, faculty and administrators of teacher education institutions and programs, community activists, private businesses and state administrators

National Education Association: represents 2.1 million K-12 classroom teachers, professors, educational support personnel and students

National Head Start Association: represents 5,000 professionals working with Head Start programs nationwide

National Indian Education Association: represents 2,700 individuals dedicated to promoting quality education for American Indian and Alaskan Native people.

National Medical Association: represents 16,500 primarily African-American minority physicians

National Mental Health Association: represents 450 local affiliate mental health associations, comprised of mental health care providers and clients, and community mental health centers

National Perinatal Association: represents 2,500 physicians, nurses, nurse-midwives, social workers and consumers of perinatal services

The National PTA: represents 6.8 million parents, K-12 classroom teachers, principals, school administrators and students

National Rural Health Association: represents 2,000 community, migrant and homeless health centers and their staffs

National School Boards Association: represents 52 state school board associations

National School Public Relations Association: represents 2,200 teachers, principals, administrators, retired teachers, students and public relations personnel

Society for Neuroscience: represents 21,219 neuroscientists

Zero to Three: represents 7,500 programs for high risk children and families, as well as individuals

Appendix C

Florida State Health/Education Consortium – Steering Committee Members and Sample Agenda

Steering Committee Members

Honorable Lawton Chiles, Co-Chair
Governor
State of Florida
The Capitol, PL05
Tallahassee, FL 32399-0001

Honorable Betty Castor, Co-Chair
Commissioner Department of Education
The Capitol, PL08
Tallahassee, FL 32399-0400

Mary Apple
Health Services and Facilities Consultant
HRS Family Health Services, HSF
Bldg., 1 Rm. 115, 1317 Winewood Blvd.
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Jean Battaglin
Community Health Nursing Consultant
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Agenda

FLORIDA'S HEALTH/EDUCATION CONSORTIUM
September 19 & 20, 1994
Ramada Inn North
Tallahassee, Florida

1:00 P.M.
WELCOME - Dr. Charles Mahan, State Health Officer
DEVELOPMENT OF FLORIDA'S HEALTH/EDUCATION CONSORTIUM - Patsy Palmer
CDC INVOLVEMENT - Mae Waters
EIGHT COMPONENTS - Sylvia Byrd
INTRODUCTIONS - Mae Waters
OVERVIEW OF COMPONENTS AND MATERIALS AND DESCRIPTION OF GROUP WORK - Joe Pascarelli
SMALL GROUP SESSIONS
- Policy
- Awareness and Resources
- Educational Outcomes & Standards
- Professional Preparation & Practice
- Family & Community Involvement

4:30 P.M. - **ADJOURN**

5:30 P.M. - **RECEPTION AT THE GOVERNOR'S MANSION**

September 20, 1994

8:30 A.M.
WELCOME & ANNOUNCEMENTS - Mae Waters

9:00 A.M.
SMALL GROUP & SHARING SESSIONS - Joe Pascarelli
- Policy
- Awareness and Resources
- Educational Outcomes & Standards
- Professional Preparation & Practice
- Family & Community Involvement

12:00 P.M. - **LUNCH**
SMALL GROUPS & SHARING SESSIONS - Joe Pascarelli
ACTION PLANS FOR FUTURE MEETINGS
ORGANIZATIONAL SUPPORT

3:00 P.M. - **EVALUATION**
Patsy Palmer
Mae Waters
Sylvia Byrd
PARTING COMMENTS
National Representatives

3:30 P.M. - **ADJOURN**

Gene Witt
President
School Superintendents Association &
Superintendent of Manatee County
Schools
P.O. Box 9069
Bradenton, FL 34206-9069

Frances Yeo
President of Escambia P.T.A.
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Appendix D

Maryland State Health/Education Consortium – Steering Committee Members and Sample Agenda

Steering Committee Members

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Agenda

Second Governor's Summit on School-Linked Health Services
for Children and Their Families
HEALTHY FAMILIES, HEALTHY SCHOOLS
A CALL TO ACTION
October 13, 1994 • 8:30 am - 3:00 pm
University College Conference Center • University of Maryland College Park

8:30 - 9:15 A.M. -
Registration &Continental Breakfast and Exhibitors

9:15 - 9:30 A.M. - WELCOME
Ancelmo E. Lopes
Summit Chairperson
President, Mid-Atlantic Health Care Plan Prudential Health

9:30 - 10:15 A.M. - KEYNOTE ADDRESS
Michael D. Usdan, EdD
President, Institute for Educational Leadership

10:15 - 10:45 A.M. - REMARKS AND PRESENTATION
Governor William Donald Schaefer

10:45 - 11:00 A.M. - BREAK WITH EXHIBITORS

11:00 A.M. - 12:15 P.M.
CONCURRENT WORKSHOPS:
Workshop A
Hurlock's Helping Hands: Teaching Social Skills and Peer Mediation
Dale F. Carrier
Gail S. Aveson, BA, MEd

Workshop B
Western Maryland AHEC Adolescent Coalitions: Lessons Learned
Susan O. Davis, MEd
Sheryl A. Ryan, MD

Workshop C
School Based Infant Care: Parents and Babies Learning Together
Jeanne M. Page, MA
Karen L. Roe

Workshop D
Partners Promoting Success to Create Healthy Students and Families
Dorothy P. Giersch

Workshop E
Maryland Making the Grade: An Update on School Based Health Centers in Maryland
Genie L. Wessel

12:15 - 12:45 P.M.
Appetizer and Networking in Exhibit Area

12:45 - 1:30 P.M.
Luncheon

1:30 - 2:00 P.M.
Remarks
Dr. Nancy Grasmick
Maryland State Superintendent of Schools

2:00 - 3:00 P.M.
Dessert and Networking in Exhibit Area

3:00 P.M.
Adjournment

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Continued on next page

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Appendix E

New Mexico State Health/Education Consortium – Steering Committee Members and Sample Agenda

Members

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Agenda

SCHOOL AND COMMUNITY:
SOLVING HEALTH PROBLEMS TOGETHER
The Taos Convention Center
Taos, New Mexico

October 17, 1994

11:30 A.M. - FACILITATORS' MEETING
Chuck Spath

12:00 - 1:00 P.M. - REGISTRATION

1:00 - 2:00 P.M. - FIRST PLENARY SESSION
- Presiding - Caroline Gaston
- Welcome - Taos Mayor Fred Peralta
- Conference Overview - Bill Blair
- Introductions - Caroline Gaston
- Youth Perspective - Phillip Gallegos
  Matthew Vigil
- State Perspective - Ann Taulbee
  Bill Blair
  Caroline Gaston

2:15 - 5:00 P.M. - COMMUNITY GROUP WORKING SESSIONS

5:30 - 6:15 P.M. DINNER

6:15 - 7:15 P.M. SECOND PLENARY SESSION
- Conference Challenge - First Lady Alice King
- Brief Progress Reports from Community Groups

October 18, 1994

8:00 - 8:30 A.M. - BREAKFAST
- Reactions to first day and challenge -
  Ann Taulbee, Bill Blair, Caroline Gaston

8:45 - 10:45 A.M. - COMMUNITY GROUP WORK SESSIONS

11:00 A.M. - 12:15 P.M. - FINAL PLENARY SESSION
- Reports by Community Groups
- Keynote by Tamara Copeland, Director, National Health & Education Consortium
- Closing comments - Caroline Gaston

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Appendix F

Texas State Health/Education Consortium / Texas Comprehensive School Health Initiative Steering Committee Members and Sample Agenda

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Agenda

Texas Comprehensive School Health Initiative

TEXAS SCHOOL HEALTH SUMMIT: WORKING TOGETHER FOR THE FUTURE

November 3-5, 1993

Del Lago Conference Center

November 3, 1993

10:00 - 11:30 A.M. - SUMMIT REGISTRATION

12:00 P.M. - WELCOME

Opening Session Luncheon

Mike Hill & Nick Iammarino
American Cancer Society, TCSHI

Brenda Leath, National Health & Education Consortium

Keynote Speakers

Guy Parcel, Director
Center for Health Promotion University of Texas Health Science Center

Pat Cooper, Executive Director
National School Health Education Coalition

David Smith, Commissioner of Health State of Texas

Charge to Group:
Nick Iammarino

3:00 P.M. - BREAK & HOTEL CHECK-IN

3:30 P.M. - Convene in six work groups as assigned. Development of a Concept Statement, analysis of the issue. Each work group will have 2 facilitators and a recorder to guide the process.

6:30 P.M. - RECEPTION AND FAJITA DINNER

November 4, 1993

7:00 A.M. - BREAKFAST

8:00 A.M. - OPENING REMARKS

8:15 A.M. - Review six concept statements developed by each group.

9:00 A.M. - BREAK

9:30 A.M. - Reconvene in six work groups. Develop action plan specific to each of six critical issues.

12:00 P.M. - LUNCH

1:00 P.M. - SIX WORK GROUPS - CONTINUE.

3:00 P.M. - BREAK

3:30 P.M. - SIX WORK GROUPS - CONTINUE.

6:30 P.M. - DINNER

November 5, 1993

7:00 A.M. - BREAKFAST

8:00 A.M. - GENERAL SESSION:
Opening remarks and reports from critical issue groups.

9:45 A.M. - BREAK

10:00 A.M. - CLOSING REMARKS

Keynote Speakers:

Skip Meno, Commissioner of Education State of Texas

Joycelyn Elders, Surgeon General of the United States

12:00 P.M. - CLOSING REMARKS AND ADJOURN.

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National Health & Education Consortium Publication Order Form

Please indicate the number of publications requested in the spaces provided.

○ **Starting Young: School-Based Health Centers at the Elementary Level** (Special Report) — provides historical and current info. on school-based health care with additional info. on staffing patterns, funding, and the value of preventive health care to elementary age children; produced in collaboration with the National Association of Elementary School Principals. (1995, $10)

○ **Putting Children First: State-Level Collaboration Between Education and Health** (Special Report) — describes interventions used in four pilot states (Florida, Maryland, New Mexico and Texas) to promote collaboration between the health and education sectors; provides suggestions to state leaders working to foster similar collaborative relationships. (1995, $10)

○ **Fetal Alcohol Syndrome: The Impact on Children's Ability to Learn** (Occasional Paper #10) — examines the root causes and consequences of Fetal Alcohol Syndrome and its impact on a child's ability to learn; describes some innovative programs and suggests recommendations for action; produced in collaboration with the Children of Alcoholics Foundation. (1994, $5)

○ **Texas' Youth, Texas' Future** (Special Report) — produced for NHEC by IEL's Center for Demographic Policy, identifies the demographic trends of Texas' children at health and educational risk and provides data to facilitate collaborative planning strategies for the education and health systems. (1993, $12)

○ **Florida's Youth, Florida's Future** (Special Report) — produced for NHEC by IEL's Center for Demographic Policy, identifies the demographic trends of Florida's children at health and educational risk and provides data to facilitate collaborative planning strategies for the education and health systems. (1993, $12)

○ **School Nursing: Trends for the Future** (Occasional Paper #9) — Carole Passarelli of the Yale School of Nursing highlights the increased need for school health nurses — providing recommendations for the best use of these essential professionals, illustrating various settings in which school nurses play an integral role, and describing current progressive school nurse programs. (1993, $5)

○ **Eat to Learn, Learn to Eat: The Link Between Nutrition and Learning in Children** (Special Report/Occasional Paper #7) — provides an overview of the link between nutrition and learning in children; describes the successes and limitations of public and private child nutrition programs; suggests action steps improve children's nutritional status; produced in collaboration with the American School Food Service Association. (1993, $10)

○ **Children's Mental Health and Their Ability to Learn** (Occasional Paper #8) — written by the National Mental Health Association, examines the current status of children's mental health and its impact on children's ability to learn; includes info. on services available to address needs and suggests policy and action steps to improve the provision, availability and accessibility of these services. (1993, $5)

○ **The Poisoning of America's Children: Lead Exposure, Children's Brains and the Ability to Learn** (Occasional Paper #6) — Dr. Herbert Needleman of the University of Pittsburgh provides a comprehensive overview of lead poisoning, presenting research that demonstrates the long and short-term effects of low level lead exposure on children's intellectual ability and social adjustment. (1992, $5)

○ **Health/Education Collaboration: Insights Into Six Field Activities** (Occasional Paper #5) — describes five NHEC-sponsored community initiatives and analyzes implications for future activities. (1992, $5)

○ **Bridging the Gap: An Education Primer for Health Professionals/A Health Care Primer for Education Professionals** (Special Report) — this two-part primer describes the health and education systems and how professionals from both fields can work collaboratively. (1992, $12)

○ **At Risk Does Not Mean Doomed** (Occasional Paper #4) — Craig T. Ramey and Sharon L. Ramey, Co-Directors of the Civitan International Research Center of the University of Alabama at Birmingham, analyze the results of their research in early intervention programs for children. The research not only shows that these programs can significantly improve school readiness, but moreover demonstrates that certain types of children are in greater need of early intervention. (1992, $5)

○ **Creating Sound Minds and Bodies: Health and Education Working Together** (Special Report) — examines health/education policy environments and suggests collaboration at the federal, state and local levels; catalogues ongoing activities and provides an annotated bibliography of resources. (1992, $10)

○ **Cocaine-Exposed Children: A Growing Health/Education Issue** (Occasional Paper #3) — provides an overview of how cocaine and general drug use during pregnancy affect the health and ultimate learning potential of infants; offers action steps to help prevent the problems associated with drug exposure during pregnancy. (1992, $5)

○ **"Help Me Learn, Help Me Grow"/"Ayudame A Aprender, Ayudame A Crecer"** (Project Materials) — a bilingual, multi-media, parent awareness project. Materials are designed to be administered by professionals to help educate parents on the link between their child's health and education. [Starter Set — 1 video (Spanish or English), 40 posters/primers (Spanish, English, or mixed), 20 magnet/notepad sets, 1 community action guide — $28 — note: circle desired language of materials] Items are also sold individually.

○ ___ # English starter set (English video)
___ # English posters
Spanish posters

○ ___ # Spanish starter set (Spanish video)
___ # English posters
Spanish posters

A list of publications produced prior to 1992 can be obtained by contacting the NHEC offices.

Bulk rate discounts of 50% off are available for orders of 50 or more of a given publication.

To avoid shipping and handling charges, please include a check with this order form.

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National Health & Education Consortium
c/o The Institute for Educational Leadership
1001 Connecticut Ave, NW; Suite 310
Washington, DC 20036
(202) 822-8405

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Organization _____

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NHEC Core Consultants

Tamara Lucas Copeland, MSW, Director

Ms. Copeland has twenty years of experience working with local, state, regional and national decision-makers as a child advocate. She has worked for state legislators, governors and for Congress on education, health and human services issues and has substantial expertise in group facilitation, political marketing and strategic planning.

Christopher Shearer, MA, Program Associate

Mr. Shearer, formerly of the philanthropic community, has broad experience with cross-sector reform. His expertise lies in packaging concepts and generating creative ideas to meet the somewhat different, but often complementary objectives of the health and education communities. He is well-versed on school readiness, public/private partnerships, and higher education reform.

Christina Foley, MSPH, Program Associate

Ms. Foley has, a Masters Degree in Public Health and has been an elementary and secondary school teacher. She is able to serve as a dialogue facilitator between the health and education communities, particularly at the practitioner level, assisting in the development of agendas and plans to meet the needs of both communities. She also serves as the primary staffer on "Help Me Learn, Help Me Grow", an NHEC-developed, bilingual, multimedia initiative to enrich the parenting knowledge of the parents of young children.

For more information on NHEC's services, fees and publications, contact Christina Foley at:

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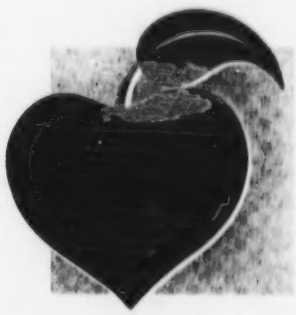
National Health & Education Consortium
was provided by the AT&T Foundation
and the Honeywell Foundation.
Ongoing support for the
National Health & Education Consortium
is provided by the Prudential Foundation.



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